

FOR STATE
HEALTH DEPT.

11631

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11625

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>9 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Rt # 4</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Clifton</u> Last <u>Ray</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>19 66</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cole</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-12-25</u> 41 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Const Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CO Masons Ecco Const.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Ray</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jones Huntington-Md</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-24-43080</u>		17. INFORMANT <u>Leticia Howe (Sister)</u> Address <u>Same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries. Severe -</u> 9023 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Trauma from fall of 70 some feet -</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from 6th floor of building landing on concrete</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11:45</u> <u>8/25</u> 19 <u>66</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bldg</u>		20f. (City or town) (County) (State) <u>Bethesda. Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED <u>8/25/66</u>
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
EXAMINER'S NAME (Type) <u>John B. Ball</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-30-66</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>St. Edmonds Ch. Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Sunderland Cal. Md.</u>	
24. FUNERAL DIRECTOR <u>P.E. Sewell Prince</u> Frederick Md.				25a. REC'D BY REGISTRAR DATE <u>SEP 2</u> 1966		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. For pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11632

11632

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11632

CERTIFICATE OF DEATH

11626

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>19 hrs 15 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>1026 Quebec Terrace</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Boy</u> Last <u>Reed</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/22/66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>0</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOSEPH</u>		14. MOTHER'S MAIDEN NAME <u>CAROLYN Burgess</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7600 Cerelectasis, bilaterally</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Central Nervous System Damage</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>6 AM 8-23 1966</u> , to <u>11:30 PM</u> , that (1) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>2 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Francis J. Troendle</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u>		22d. ADDRESS <u>50 W. Edmondston Drive, Rockville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>8/25/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>1331 Rockville Pike</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 25 1966</u>			

63017

SEAL

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONTGOMERY COUNTY, MARYLAND				MONTGOMERY COUNTY, MARYLAND			
1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 11 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN HOSP.				d. STREET ADDRESS 7304 XXXXX MAPLE AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle REICHARD Last REICHARD				4. DATE OF DEATH Month AUGUST Day 20 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/28/84	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 20 Days 19 Hours 66		IF UNDER 24 HRS. Hours 66 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Grocery Clerk		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Reichard				14. MOTHER'S MAIDEN NAME Susan A. Speilman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-09-4809		17. INFORMANT Nephew (K.G. Fernald)		Address Same as above.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Gastric Contents. 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Contusion & Fractured Skull. DUE TO (c) 1 Pk. 1. 1. 1. 1.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs at his home					
20c. TIME OF INJURY Month, Day, Year Hour 4:15 min. p.m. 8 19 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Chevy Chase Montg Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John V. Ball M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 8/20/66	
EXAMINER'S NAME (Type) John V. Ball				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Joseph Gawler's Sons, Inc., 5130 Wisc. Ave., N.W. Wash., D.C.				25a. REC'D BY REGISTRAR DATE AUG 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-23-1966		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Prince Georges Co. Md.		23d. LOCATION (City or Town) (County) (State)	

11083

11083



11083

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11634

CERTIFICATE OF DEATH

11628

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 28 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Russell Middle Charles Last REILLY		4. DATE OF DEATH Month August Day 17 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1903
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New Hampton, Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Reilly		14. MOTHER'S MAIDEN NAME Pearl V. Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO. 18-19-1920	
17. INFORMANT Mrs. Eleanor Reilly, 60 N.W. 196th St.		Address Fla.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Heart Disease DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ① Carcinoma Esophagus ② Aortic Abd. Aneurysm			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from July 20 , 19 66 , to August 17 , 19 66 that (x) (we) last saw the deceased alive on August 17 , 19 66 , and that death occurred at 5:45 A M, from causes and on the date stated above.			
22a. SIGNATURE J. T. Mullen		22b. DATE SIGNED Aug. 17, 1966	
22c. PHYSICIAN'S NAME (Type) J. T. Mullen, M. D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/22/66	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Va.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Nalley's Funeral Home		25a. REC'D BY REGISTRAR AUG 22 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

11828

11834

STATE OF DEATH

Florida

Hospitals

Savannah (trial)

20 days

Miami

U. S. Naval Hospital

60 Northwest Avenue E.

Baltimore

Charles

Ruth

August 17

Main

Dec. 9, 1908

U. S. Navy

New England, Iowa

Charles E. Kelly

Frank V. Miller

Mrs. Eleanor Kelly, 60 N.W. 10th St.
Miami, Fla.

J. T. Miller, M. D.

U. S. Naval Hospital, Baltimore, Md.

Arlington National Cemetery Arlington, Va.

800 Rhode Island Ave., N.E., Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL EXAMINER NOTIFIED AND APPROVED BY: *DR. B. J. D.*

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
11635						11629							
1. PLACE OF DEATH COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b <i>7 hrs.</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring, Md.</i> d. STREET ADDRESS <i>1805 Tunis Road.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Laura B. Renshaw</i>			4. DATE OF DEATH Month <i>August</i> Day <i>7</i> Year <i>1966</i>			5. SEX <i>Female</i>			6. COLOR OR RACE <i>White</i>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>4/11/84</i>			9. AGE (In years last birthday) <i>82</i> yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>8</i> Days <i>2</i> Hours <i>15</i> Min. <i>15</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			11. BIRTHPLACE (County & State, or foreign country) <i>District of Col.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Louie VanSogen Ray</i>						14. MOTHER'S MAIDEN NAME <i>Ella J. Renshaw</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>						16. SOCIAL SECURITY NO. <i>None</i>							
17. INFORMANT <i>Laurea J. Renshaw</i>						18. ADDRESS <i>1805 Tunis Rd. Silver Spring, Md.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhagic Necrosis Small Bowel</i> DUE TO <i>Superior Mesenteric Artery Insufficiency</i> DUE TO <i>Aortic Atherosclerosis</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. <i>4221</i>												INTERVAL BETWEEN ONSET AND DEATH <i>20 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Atherosclerotic Cardiovascular Disease</i>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>63</i> , to <i>Aug</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Aug 6</i> , 19 <i>66</i> , and that death occurred at <i>3:15</i> M, from the causes and on the date stated above.													
22a. SIGNATURE <i>Bernard A. Fitzgerald</i>												22b. DATE SIGNED <i>Aug 7, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>BERNARD A. FITZGERALD</i>												22d. ADDRESS <i>SILVER SPRING, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>Aug. 10, 1966</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Congressional Cemetery</i>					
23d. LOCATION (City, town or county) (State) <i>Washington, D.C.</i>													
24. FUNERAL DIRECTOR <i>John B. Thomas</i>				24a. ADDRESS <i>8454 Georgia Ave. Silver Spring, Md.</i>				25a. REC'D BY REGISTRAR <i>AUG 11 1966</i>					
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>													

11632

11632

Montgomery

Montgomery

7th Silver Spring, Md

Silver Spring

1805 Turner Road

11652 Highway

August 7 11

Laure

4/11/84 82

Female white

U.S.A.

District of Col

San Francisco

San Francisco

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11636 CERTIFICATE OF DEATH 11636									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 29 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Maryland					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY North Bergen c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1404 - 43rd Street d. STREET ADDRESS 1404 - 43rd Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Salvatore Middle (NMN) Last Ricco					4. DATE OF DEATH Month August Day 30 Year 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 January 1915		9. AGE (In years last birthday) 51 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph Ricco					14. MOTHER'S MAIDEN NAME Antonina Ricco				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records, The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 410X DUE TO Aortic insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease (Mitral stenosis & DUE TO (c) Prosthetic mitral valve replacement								INTERVAL BETWEEN ONSET AND DEATH 12 Hours 13 Years 6 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute renal failure----24 Hours, Right Cerebrovascular accident								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 1 , 19 66 , to August 30 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 30 , 19 66 , and that death occurred at 11:50 P.M. on the causes and on the date stated above.									
22a. SIGNATURE R. Darryl Fisher, MD		22b. DATE SIGNED 31 August 1966		22c. PHYSICIAN'S NAME (Type) R. Darryl Fisher, MD.					
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Trans-burial		23b. DATE THEREOF Sept. 3, 1966		23c. NAME OF CEMETERY OR CREMATORY Union City, New Jersey		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR C. Glen Carter Warner E. Pumphrey, Inc.		ADDRESS 8434 Ga. Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR SEP 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

11558

Nonchance

Bedside

19 Jan North Bergen

The Clinical Center, Bethesda, Md., Maryland JADA - 43rd Annual

Salvatore (Mrs) 30 Jan 1915

Wife

31 Jan 1915

Indoor

Bed Jersey

USA

Joseph Hideo

Archonina Hideo

40

123-70-3823 The Clinical Center, Bethesda, Md., Maryland

Acute pulmonary edema

Acute pulmonary edema

12 hours

Chronic heart disease (Mitral stenosis)

13 years

Prosthetic mitral valve replacement

6 days

Home care (Home) 12 hours, Night Care (Home) 12 hours

August 30 1965

August 1 1965

12:32 P.M.

A. David Fisher, MD.

Institution of Health, Bethesda, Md., The Clinical Center, Division of

11631

CERTIFICATE OF DEATH

11637

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>48 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>506 Easley St. Apt 304</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard George</u> First <u>Richardson</u> Middle Last				4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/11/24</u>	9. AGE (In years last birthday) <u>42</u> Yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Mr. George Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Gant</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-6868</u>		17. INFORMANT <u>Mrs. Lois M. Richardson</u> Address <u>506 Easley St. S. S., Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic pyelonephritis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January, 1966</u> to <u>18 August, 1966</u> , that (I) (we) last saw the deceased alive on <u>12 August 1966</u> , and that death occurred at <u>3:40 AM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>Ira N. Tublin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/18/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ira N. Tublin</u>				22d. ADDRESS <u>800 Pershing Dr., S. S., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 20, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8454 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 22 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11631

CERTIFICATE OF DEATH

11631

Name of Deceased		Date of Birth	
Sex		Race	
Marital Status		Occupation	
Cause of Death		Place of Death	
Time of Death		Signature of Physician	
Signature of Registrar		Date of Registration	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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D.U.C.
Cleared with Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11638					11632				
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring Md.</i>			c. LENGTH OF STAY IN 1b <i>2 hours</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			d. STREET ADDRESS <i>9311 WORTH AVE</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Holy Cross Hospital</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>WALTER</i> Middle <i>R.</i> Last <i>Ridgely</i>			4. DATE OF DEATH Month <i>August</i> Day <i>2</i> Year <i>1966</i>						
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/16/02</i>		9. AGE (In years last birthday) <i>63</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired self-employed repairman</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Laundry Egpt.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Kensington, Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Harry Sansbury Ridgely</i>					14. MOTHER'S MAIDEN NAME <i>Blanche E. Repp</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>217-32-1634</i>		17. INFORMANT <i>Hazel J. Ridgely</i> Address <i>9311 Worth Ave. Silver Spring, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac tamponade with hemopericardium</i> <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>ruptured myocardial infarction</i> DUE TO (c) <i>thromboses anterior descending left coronary</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>August 2, 1966</i> , to <i>Aug - 2, 1966</i> , that (I) (we) last saw the deceased alive on <i>Aug - 2, 1966</i> , and that death occurred at <i>10:30 P</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Gene U. Cohen</i>					22b. DATE SIGNED <i>Aug. 2, 1966</i>				
22c. PHYSICIAN'S NAME (Type) <i>Gene U. Cohen</i>					22d. ADDRESS <i>1106 Spring Street, S. S., Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>Aug. 6, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Washington, D. C.</i>	
24. FUNERAL DIRECTOR <i>John B. Thomas</i> <i>Warner E. Pumphrey, Inc.</i>					25a. REC'D BY REGISTRAR <i>Charles Judge</i>				
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

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FOR STATE
HEALTH DEPT.

11639

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11633

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 10800 Georgia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Emmett Last Robbins				4. DATE OF DEATH Month August Day 23 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/25/11	
9. AGE (In years lost birthday) yrs. 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army		10b. KIND OF BUSINESS OR INDUSTRY communications		11. BIRTHPLACE (State or foreign country) Olympia, Washington	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Robbins, JOHN			
14. MOTHER'S MAIDEN NAME Bertha Ernst				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1944-64			
16. SOCIAL SECURITY NO. 1944-64				17. INFORMANT Wife, Address Mary Robbins 10800 Ga. Ave. S.S., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 4201 DUE TO Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Roach M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BELDEN R. ROACH, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22. DATE SIGNED 8/23/66				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Aug 26, 1966		23c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery	
23d. LOCATION (City or Town) Rockville, Md.				23e. REC'D BY REGISTRAR Charles Judge		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR Arthur Waters, Washington, D.C.				25. DATE AUG 26 1966		26. REGISTRAR'S SIGNATURE Charles Judge	

11037

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
11640					11634														
Item 7 Film 6579 8/9/66 mh																			
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE WASHINGTON, D.C. 473														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. 473														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON SANITARIUM & HOSPITAL					d. STREET ADDRESS 3901 CONNECTICUT AVE., N.W.														
3. NAME OF DECEASED (Type or print) First SARA Middle ROBERTS Last					4. DATE OF DEATH Month AUGUST Day 2, Year 1966														
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 1, 1891		9. AGE (In years last birthday) 75 yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Manager					10b. KIND OF BUSINESS OR INDUSTRY West Chem. Co.		11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U. S. A.										
13. FATHER'S NAME ABRAHAM ROBERTS					14. MOTHER'S MAIDEN NAME REBECCA SHOFNOS														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. 096-07-2447														
					17. INFORMANT Brother Address JACK ROBERTS-3901 Conn. Ave., NW														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Generalized atherosclerosis (b) DUE TO Hypertension (c) 10 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive Heart Failure INTERVAL BETWEEN ONSET AND DEATH 3 weeks 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)					21. I certify that (I) (this hospital) attended the deceased from July 30, 1966, to Aug 2, 1966 that (I) last saw the deceased alive on Aug 2, 1966 and that death occurred at 1:35 PM from the causes and on the date stated above.														
22a. SIGNATURE Joseph H. Watson					22b. DATE SIGNED Aug 2 1966														
22c. PHYSICIAN'S NAME (Type) JOSEPH H. WATSON, M.D.					22d. ADDRESS 3201 Wisconsin Ave., NW														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 8-5-66														
23c. NAME OF CEMETERY OR CREMATORY Shev Shalom Talmud Torah Cem. Wash., D.C.					23d. LOCATION (City, town or county) (State)														
24. FUNERAL DIRECTOR Bernard Danzansky & Sons					25a. REC'D BY REGISTRAR AUG 5 1966														
25b. REGISTRAR'S SIGNATURE Charles Judge																			

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11641

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11635

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b -		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u>				d. STREET ADDRESS <u>10303 Haywood Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Russell Clifford Robertson</u>				4. DATE OF DEATH Month Day Year <u>August 15 1966</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-1959</u>		9. AGE (In years lost birthday) yrs. <u>7</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>na</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PATRICK THOMAS ROBERTSON</u>				14. MOTHER'S MAIDEN NAME <u>PEBBY ANNE WHITT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>na</u>		16. SOCIAL SECURITY NO. <u>na</u>		17. INFORMANT Address <u>SIL. SP. MD</u> <u>RUSSELL C. WHITT-10303 HAYWOOD DR</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPH. 4 x 10</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Drowning</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped in Neighbors Pool with clothes on & drowned.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10</u> <u>8/15</u> <u>1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Swimming Pool</u>		20f. (City or town) (County) (State) <u>Silver Spring Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>8/15/66</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>SILVER SPRING MONT. CO. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		23d. LOCATION (City or Town) (County) (State) <u>SILVER SPRING MONT. CO. MD.</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, INC. SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Washington, D.C.

April 18, 1964

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11642

CERTIFICATE OF DEATH

11636

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 1 mo. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 19. STATE Washington, D. C. b. COUNTY 47-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4000 Mass. Ave., NW, Wash., D. C. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (last) Rohrbach - - James Peter Rohrbach First James Middle Peter Last 4. DATE OF DEATH Month Aug. Day 7 Year 1966		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9/29/1897 9. AGE (In years last birthday) 68 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Treasurer 10b. KIND OF BUSINESS OR INDUSTRY Bureau of Natl. Affairs 11. BIRTHPLACE (County & State, or foreign country) New York City, N. Y. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Rohrbach 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWI Army 16. SOCIAL SECURITY NO. 115-05-1822 17. INFORMANT Rev Peter Thomas Rohrbach Address 2131 Lincoln Rd Wash. DC N.E.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) 10 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Vascular Accident 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Jan. , 19 66 , to Aug. 7 , 19 66 , that (I) (we) last saw the deceased alive on Aug. 7 , 19 66 , and that death occurred at 2:00 PM , from causes and on the date stated above. 22a. SIGNATURE James L. Loubach M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) James L. Loubach 22d. ADDRESS 1903 Woodland Way, Adelphi, Md. 22b. DATE SIGNED 8/7/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF Aug 10, 1966 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem 23d. LOCATION (City or Town) (County) (State) Washington DC		24. FUNERAL DIRECTOR Robert A. De Jr ADDRESS Deloit Funeral Home Wash DC 25a. REC'D BY REGISTRAR DATE AUG 12 1966 25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11643

11637

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN 9 Hosp</u>				d. STREET ADDRESS <u>2445 BRIGGS CHASE RD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE CECILIA RONCHI</u>				4. DATE OF DEATH Month Day Year <u>8 26 1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-13</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H/W.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH PETRO</u>				14. MOTHER'S MAIDEN NAME <u>ANTONETTE D'AMBROSIA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>PTS. RECORD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>64</u> , to <u>8-26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-26</u> , 19 <u>66</u> , and that death occurred at <u>11:00 A.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Stuart Nelson</u>				22b. DATE SIGNED <u>8-26-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>STUART L. NELSON</u>				22d. ADDRESS <u>831 Annapolis Boulevard Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor, Pro Geo Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>F. Gasch's Sons Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 30 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

11638

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Carolina b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 13 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital,		d. STREET ADDRESS 519 South Hughes Blvd.	
3. NAME OF DECEASED (Type or print) Dorothy Matilda Garries Roof		4. DATE OF DEATH Month August Day 23 Year 19 66	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1910
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 10 Days 2 Hours Min. 	
11. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Reg. Nurse/Housewife		12. KIND OF BUSINESS OR INDUSTRY N/A	
13. BIRTHPLACE (County & State, or foreign country) McKean, Pennsylvania		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME John L. Garries		16. MOTHER'S MAIDEN NAME Ella Plack	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		18. SOCIAL SECURITY NO. 564 01 7273	
19. INFORMANT Blvd. Elizabeth City, N.C.		20. CDR Claude R. Roof, USN Ret. 519 S. Hughes	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Increased intracranial pressure DUE TO 1966 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Glioblastoma (T) temporal lobe (c) 			INTERVAL BETWEEN ONSET AND DEATH 1 month 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 10 , 19 66 , to Aug. 23 , 19 66 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug. 23 , 19 66 , and that death occurred at 1215M , from causes on and the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED Aug. 24, 1966	
22c. PHYSICIAN'S NAME (Type) B. M. ONOFRIO, M. D.		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/26/1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Virginia	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE AUG 25 1966	
		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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John L. Cairns

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN lb 1 1/2 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home						d. STREET ADDRESS 1202 Lebanon Street					
3. NAME OF DECEASED (Type or print) First Middle Last Benjamin (no middle name) Rothkin						4. DATE OF DEATH Month Day Year August 28 19 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/7/1889		9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owned laundry				10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (County & State, or foreign country) Russia				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Max Rockkind						14. MOTHER'S MAIDEN NAME Mollie Bernstein					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 220-07-2077		17. INFORMANT Mrs. Anna Rothkin				Address Same as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Arteriosclerotic Cerebrovascular Disease DUE TO (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Kepone's Hemorrhagic Sarcoma											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7-1 , 19 66 , to 8-28 , 19 66 , that (I) (we) last saw the deceased alive on 8-26 , 19 66 , and that death occurred at 3:45 PM , from causes and on the date stated above.											
22a. SIGNATURE Morton Altschuler						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/28/66			
22c. PHYSICIAN'S NAME (Type) Dr. Morton Altschuler						22d. ADDRESS 9205 New Hampshire Ave., Silver Spring,					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 30, 1966		23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cemetery		23d. LOCATION (City or Town) (County) (State) Hyattsville, Md.					
24. FUNERAL DIRECTOR Goldberg James						ADDRESS 4479 30th Ave		25a. REC'D BY REGISTRAR DATE SEP 1 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Va.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>25 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Helington</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>1223 N. Evergreen</u> ST.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Edmund J. Ryan</u> First Middle Last		4. DATE OF DEATH <u>8</u> - <u>31</u> 19 <u>66</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-14-06</u> 59 Yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Wash D.C.</u>
13. FATHER'S NAME <u>Edward Ryan</u>		14. MOTHER'S MAIDEN NAME <u>Mary Malone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-20-4351</u>	17. INFORMANT <u>Wife - Eileen</u> Address <u>Same</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma, right</u> <u>1621</u> DUE TO <u>metastasis to liver and bone</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>metastasis to liver and bone</u> (c) <u>metastasis to liver and bone</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema and chronic bronchitis</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1935</u> , to <u>Aug 31</u> , 19 <u>66</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Aug 31</u> , 19 <u>66</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Delwitt E. DeLauter</u>		22b. DATE SIGNED <u>Aug 31, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Delwitt E. DeLauter</u>		22d. ADDRESS <u>3848 Boker St NW Wash D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3 Sept. 66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Virginia</u>
24. FUNERAL DIRECTOR <u>Arlington Funeral Home</u> ADDRESS <u>3901 N. Fairfax Dr.</u>		25a. REC'D BY REGISTRAR <u>SEP 2 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

14011

STATE OF TEXAS

14011

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11647

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11642

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San & Hospital</u>				d. STREET ADDRESS <u>1230 Pine Crest Circle</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Clark</u> Last <u>Salyer</u>				4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-16-02</u> 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Zoologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Dept. of Int.</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Clark Salyer</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Mabel E. Salyer 1230 Pine Crest Circle</u> Address <u>Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Artery Heart Disease</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>13R</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap, M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Belden R. Reap, M.D., Wheaton, Md.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>8/17/1966</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 23, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons, Kansas</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		ADDRESS <u>434 Georgia Ave</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11031

11031

11031

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11648

CERTIFICATE OF DEATH

11643

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Arlington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4530 40th St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDITH MARIE SCATES</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 19 1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 26, 1881</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Sims</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth McClew</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Son Charles Scates - Above</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS, (R) MIDDLE CEREBRAL ART.</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE WITH ATRIAL FIBRILLATION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 HOURS</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/1/65</u> , 19 <u>65</u> , to <u>AUG 19</u> , 19 <u>66</u> , that (I) was last saw the deceased alive on <u>AUG 18</u> , 19 <u>66</u> , and that death occurred at <u>15M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Frederick S. Caldwell.</u> M.D.		22b. DATE SIGNED <u>8-19-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S. CALDWELL, MD</u>		22d. ADDRESS <u>TENLEY BLVD ROCKVILLE, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/22/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Morris</u> ADDRESS <u>3901 No. Fairfax Dr. Arlington, Virginia</u>		25a. REC'D BY REGISTRAR <u>AUG 23 1966</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

65411

22311

11649

CERTIFICATE OF DEATH

11644

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY in 1b <u>4 days</u>		d. STREET ADDRESS <u>1504 Flower Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carl</u> First Middle Last <u>Schreiber</u>		4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-17</u> 9. AGE (In years last birthday) <u>48</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Procurement Officer USAF</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>USA</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HMAN SCHREIBER</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWII</u>		16. SOCIAL SECURITY NO. <u>116-05-6322</u>	
17. INFORMANT <u>CORA SCHREIBER</u> Address <u>(see 2 above)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSION</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-13</u> , 19 <u>66</u> , to <u>8-17</u> , 19 <u>66</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>8-17</u> , 19 <u>66</u> , and that death occurred at <u>4:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Samuel A. Hillman</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/17/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL A. HILLMAN</u>		22d. ADDRESS <u>8829 FLOWER AVE. S.S. Md. 20901</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/19/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARL. NATL Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>ARL., VA.</u>
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME</u> ADDRESS <u>4217 - 9th St. N.W. D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
		DATE <u>AUG 22 1966</u>	

11694

CERTIFICATE OF DEATH

11694

Form with multiple sections and fields, including a large central area for text and a smaller section at the bottom right. The form is heavily faded and contains illegible text.

101 (M)
FOR STATE
HEALTH DEPT.

11650

11650
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11645

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baithersburg</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Millcreek School grounds</i>		d. STREET ADDRESS <i>Route 5 Box 8 1/2</i>	
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Nathan</i> Last <i>Scott</i>		4. DATE OF DEATH Month <i>Aug</i> Day <i>23</i> Year <i>1966</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 14, 1914</i>
9. AGE (In years last birthday) <i>52</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gardner</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>CHARLES SCOTT</i>		14. MOTHER'S MAIDEN NAME <i>MARYHA L. SCOTT</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>213 14 747</i>	
17. INFORMANT <i>—</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crushed Skull + Maceration of Brain</i> 9128 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Trauma from Mower machine</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>was adjusting blades of mower head caught on blades</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>—</i>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John S. Ball</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>8/23/66</i>	
EXAMINER'S NAME (Type) <i>John S. Ball</i>		22. DATE SIGNED <i>8/23/66</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>8-28-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Grasonville Cem</i>
23d. LOCATION (City, town or county) (State) <i>Grasonville Md.</i>		24. FUNERAL DIRECTOR <i>James B. Marshall Easton, Md.</i>	
25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

11045

11045

MECHANICAL EXAMINER'S CERTIFICATE OF DESIGN

[Faint, mostly illegible text and lines, likely bleed-through from the reverse side of the document. Some faint words like "DESIGN" and "CERTIFICATE" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. Page 1 and 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

6-223433

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11651 CERTIFICATE OF DEATH 11646											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY in lb <u>59 hr 49 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				d. STREET ADDRESS <u>6620 SULKEY LANE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>M</u> Last <u>SCRUGGS</u>						4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-13-66</u>		9. AGE (In years last birthday) <u>--</u> yrs. IF UNDER 1 YEAR Months <u>--</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>--</u> Min. <u>--</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MONT. CO. MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HENRY C SCRUGGS</u>						14. MOTHER'S MAIDEN NAME <u>JOYCE TAMALOI</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HENRY C SCRUGGS md</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>7735</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <u>Pneumonia 18 & Prematurity</u> DUE TO (c) <u>59 hr 9 min</u>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>					
20c. TIME OF INJURY Hour a.m. <u>---</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) <u>---</u> (County) <u>---</u> (State) <u>---</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>8/13/66</u> 19 <u>66</u> to <u>8/16/66</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/15/66</u> 19 <u>66</u> , and that death occurred at <u>12:34</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>J. W. Stohlman M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>---</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. W. STOHLMAN M.D.</u>						22d. ADDRESS <u>4711 CHASE AVE BETH. MD 20014</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/19/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>				23d. LOCATION (City, town or county) <u>Silver Spring</u> (State) <u>Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>						ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>AUG 19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11846

11851

None

None

NO

Robert A. Humphrey
Bethesda, Maryland
Age 75
Gate of Heaven Cemetery Silver Spring Maryland
Buried

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR-STATE
HEALTH DEPT.

11652

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11647

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>89 h. 5 min.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>2201 ARCOLA Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>RODNEY LAVERNE SENSEMAN</u>		4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-18</u> 9. AGE (In years last birthday) <u>48</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN GEN. Development Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
13. FATHER'S NAME <u>CORNELIUS EARL SENSEMAN</u>		14. MOTHER'S MAIDEN NAME <u>JESSIE FREY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>1958 ARMY - 528-01-8804</u>		16. SOCIAL SECURITY NO. <u>CHART</u> 17. INFORMANT <u>7600 Carroll Avenue</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>916.0</u> DUE TO <u>Conflagration burns, extreme,</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>of 85% to 90% of body surface.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased burned by exploding propane gas in home bomb shelter.</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:00 p.m. 8-19 1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>8/23/1966</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Wheaton</u>	
23a. BURIAL-CREATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 26-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parlison Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u> ADDRESS <u>254 Carroll St</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>AUG 26 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11043

11043

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "chart" and "map" are faintly visible.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 11653 110648 MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 102 Dawson Ave.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 102 Dawson Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ANDREW First Middle Last SHAW 4. DATE OF DEATH Month Aug. Day 15, Year 1966					5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 18 Oct. 1910 9. AGE (In years last birthday) 55 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic 10b. KIND OF BUSINESS OR INDUSTRY Auto 11. BIRTHPLACE (State or foreign country) Scotland 12. CITIZEN OF WHAT COUNTRY? US US			13. FATHER'S NAME Robert G. Shaw 14. MOTHER'S MAIDEN NAME Marion Shenkly			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) WW II 16. SOCIAL SECURITY NO. 579-10-1467 17. INFORMANT 913 Maple Ave. Robert S. Shaw- Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular Disease - DUE TO (c) 4 yrs.								INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic Alcoholism -								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8/16/66 22. DATE SIGNED									
ACTUAL SIGNATURE John G. Ball EXAMINER'S NAME (Type) John G. Ball				Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8/19/66		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Va.		
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Address Rockville, Md.					25a. REC'D BY REGISTRAR AUG 19 1966 DATE		25b. REGISTRAR'S SIGNATURE Charles Yunge		

1182

Rockville

Rockville

107 Johnson Ave.

White

White

Rockville

107

Robert A. Shan

Box 11

211 Maple Ave.

Rockville, Md.

Rockville

Robert A. Shan

Rockville

18 Oct. 1940

Shan

Aug. 14

107 Johnson Ave.

Rockville

Rockville

Rockville

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11654					11649				
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 30 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Alabama b. COUNTY Jasper c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Route 6, Box 88 d. STREET ADDRESS Route 6, Box 88 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Lora Middle Velma Last Sherer			4. DATE OF DEATH Month August Day 23 Year 1966						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 22, 1920		9. AGE (In years last birthday) 46 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Alabama			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Floyd Grace					14. MOTHER'S MAIDEN NAME Margaret Rivers				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. No		17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest due to Acute Renal failure and DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Congestive Heart Failure DUE TO (c) Rheumatic Heart Disease					INTERVAL BETWEEN ONSET AND DEATH 22 Days 1 Years 15 Years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Postoperative Mitral and Tricuspid valve replacement					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 24, 1966 , to August 23, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 23, 1966 , and that death occurred at 11:20 from the causes and on the date stated above.									
22a. SIGNATURE R. Darryl Fisher, MD			22b. DATE SIGNED P.M. 24 August 1966		22c. PHYSICIAN'S NAME (Type) R. Darryl Fisher, MD.				
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) removal			23b. DATE THEREOF 8/25/66		23c. NAME OF CEMETERY OR CREMATORY Samaria Cemetery		23d. LOCATION (City, town or county) (State) Walker County, Alabama		
24. FUNERAL DIRECTOR The S.H. Hines Co.			25a. REC'D BY REGISTRAR 2901 14th St. N.W.		25b. REGISTRAR'S SIGNATURE Washington, D.C.		25c. DATE AUG 26 1966		

11648

Alaska

Montgomery

Jaeger

30 days

Rebecca

Route 5, Box 88

The Clinical Center, Bethesda, Maryland

Sherris

Veins

Long

June 22, 1960

female

USA

Alaska

None

Honolulu

Floyd Grace

Marjorie Rivers
The Medical Records
The Clinical Center, Bethesda, Maryland
Hepatic Failure

Cardiac arrest due to acute renal failure and

congestive heart failure

Renal Failure

Postoperative Mitral and Tricuspid Valve Replacement

July 22, 1960

11:40
P.M.

August 23

24 August 1960
The Clinical Center, National
Institutes of Health, Bethesda, Md.

R. Barry Winter, MD.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and no later than 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11655

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11650

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH SAN. AND HOSPITAL</u>			d. STREET ADDRESS <u>9110 Flower Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>KATHLEEN</u> Middle <u>SHUITZ</u> Last <u>SHUITZ</u>			4. DATE OF DEATH <u>8-4-66</u> 19		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-18-66</u>	9. AGE (In years last birthday) yrs. <u>3</u> <u>17</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>17</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND D.C.</u>	
13. FATHER'S NAME <u>HERALD E. SHUITZ</u>			14. MOTHER'S MAIDEN NAME <u>BARBARA MILLER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 9240 IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> DUE TO (b) <u>due to suffocation with</u> DUE TO (c) <u>crib blanket</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Infant accidentally smothered by crib blanket</u>			
20c. TIME OF INJURY Month, Day, Year <u>6</u> <u>00</u> <u>00</u> <u>8-4</u> <u>1966</u> Hour <u>00</u> Min. <u>00</u> P.M.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Silver Spring</u>	(County) <u>Montgomery</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Belden R. Reap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>Aug. 4, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Charles Judge</u>		Address (Street, city, town, or county) <u>254 Capitol St NW DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>AUG 6, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ETHNICAN CEM.</u>		23d. LOCATION (City or town) <u>Blacksburg Va</u>	(County) <u>Go</u>
24. FUNERAL DIRECTOR <u>John J. Kelly</u>		ADDRESS <u>254 Capitol St NW DC</u>		25a. REC'D BY REGISTRAR <u>AUG 8 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11620

11620



FOR STATE
HEALTH DEPT.

11656

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11652

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>25 yr.</u>		d. STREET ADDRESS <u>604 Mansfield Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>604 Mansfield Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Janet Elizabeth Simms</u>		4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18 - 1917</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reporter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>News Paper</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel W Keller</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Fleischman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578 10 4345</u>	
17. INFORMANT <u>Jack B. Simms</u>		Address <u>604 Mansfield Rd. S. S., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intoxication</u> 871.0 DUE TO (b) <u>Overdose of Alcohol and Barbiturates</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Took overdose of Barbiturate & Alcohol</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>2:00</u> p.m. <u>8-7-</u> 1966	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Silver Spring</u> (County) <u>Montg.</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8/7/66	
Address (Street, city, town, or county) <u>7936 Old Georgetown Rd. Bethesda, Maryland</u>		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug. 11, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) <u>Silver Spring, Maryland</u> (County) (State)
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
Address <u>8434 Georgia Ave. Silver Spring, Md.</u>		DATE <u>AUG 9 1966</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11658

CERTIFICATE OF DEATH

11658

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aspen Hill		c. LENGTH OF STAY IN 1b 3 Yrs. 10 Mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aspen Hill - Rockville		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4714 Kemper Street		d. STREET ADDRESS 4714 Kemper Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FAYE L. SIMPSON		4. DATE OF DEATH Month Aug. Day 15, Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1923
9. AGE (In years last birthday) yrs. 43		IF UNDER 1 YEAR Months 1 Days 11 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Lester Lucas		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Husband Address Same as Item 2. William E. Simpson			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pul & osteo-metastatic Ca 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Carcinoma of uterine DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 7 mos 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1, 1966 , to 8/15/66 , that (I) (we) last saw the deceased alive on 8/15/66 , and that death occurred at 2:00 PM from causes and on the date stated above.			
22a. SIGNATURE Stephen N. Jones		22b. DATE SIGNED 8-15-66	
22c. PHYSICIAN'S NAME (Type) STEPHEN N. JONES, M.D.		22d. ADDRESS 809 Veirs Mill Rd., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/17/1966	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville Mtg. Co. Md.	
24. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24. REGISTRY BY REGISTRAR AUG 17 1966		25. REGISTRAR'S SIGNATURE Charles Jones	

11033

11033

END OF DEATH

5-11-10 - 10:00 AM - 10:00 AM

10:00 AM - 10:00 AM

11

11

11

11

11/17/1900

11/17/1900

11/17/1900

11/17/1900

11/17/1900

11/17/1900

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Michigan</u> b. COUNTY <u>-</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 Mo.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ann Arbor</u> <u>Munith</u>				d. STREET ADDRESS <u>R.F.D. 1</u> <u>Morganist Henry</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9300 Linden Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Ray Newton Sims</u>		First Middle Last		4. DATE OF DEATH <u>Aug. 8, 1966</u>		Month Day Year			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 24, 1884</u>		9. AGE (In years last birthday) <u>81</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter-decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Robert Sims</u>		14. MOTHER'S MAIDEN NAME <u>Esther Schacter</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>383-03-3205</u>		17. INFORMANT <u>Daughter Helen Sims</u>		Address <u>Same as Item 1</u> <u>Linden Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> <u>4201</u> DUE TO (b) <u>Cardio Vascular Disease</u> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Years</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>John G. Ball</u>		EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>8/8/66</u>			
Address (Street, city, town, or county) <u>Bethesda, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-11-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>			
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
				DATE <u>AUG 11 1966</u>					

11051

11051

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "California" and "District" are faintly visible.]

Attending physician due to Dr. Paul Henry out of town. Coroners notified and approved. Burial after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11659

CERTIFICATE OF DEATH

11654

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 47-3	
c. LENGTH OF STAY in 1b <u>8-10-66 to 8-30-66</u>		d. STREET ADDRESS <u>1315 Juniper St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cherry Chase Hosp. & Convalescent Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HUGH</u> Middle <u>W.</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>8</u> - Day <u>30</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 17, 1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u> Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephones</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PRINCE WILLIAM, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE WASHINGTON SMITH</u>		14. MOTHER'S MAIDEN NAME <u>FOLEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Not Available</u>	
17. INFORMANT <u>Margaret E. Smith</u>		Address <u>1315 Juniper St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis, femoral arteries</u> DUE TO (b) <u>Thrombosis, Central</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>19</u> , 19 <u>66</u> , and that death occurred at <u>12:15 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>A.W. Smith</u>		22b. DATE SIGNED <u>8/30/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.W. SMITH</u>		22d. ADDRESS <u>13018 GEORGIA AVE WHEATON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>SEPT. 2/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR <u>Hyson Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 1 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>1300 N. Street, N.W. WASHINGTON, D.C. 20005</u>	

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11054

WASHINGTON, D.C. 20001
SEP 1 1960

11660

CERTIFICATE OF DEATH

11655

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg. Rural				c. LENGTH OF STAY IN b 5yrs			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS Rural			
3. NAME OF DECEASED (Type or print) First James Middle Thomas Last Smith				4. DATE OF DEATH Month Aug Day 5th Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12 1885		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 2 Days 1	IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Va,		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jacob Smith				14. MOTHER'S MAIDEN NAME Susie Boling			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Artie M. Smith. RT 3. Gaithersburg. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma, generalized 1621 DUE TO 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Bronchogenic Squamous Cell CA, left bronchus DUE TO (c) 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema Parkinson's Disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9 Oct., 1962 to 5 Aug., 1966 , that (I) was last saw the deceased alive on 4 Aug., 1966 , and that death occurred at 12:00 M, from the causes and on the date stated above.							
22a. SIGNATURE Gordon M. Smith				22b. DATE SIGNED 5 Aug 66		22c. PHYSICIAN'S NAME (Type) Gordon M. Smith	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-6-66		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION (City, town or county) (State) Gaithersburg. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner				25a. REC'D BY REGISTRAR DATE AUG 8 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11622

CERTIFICATE OF DEATH

11622

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6-231464

VR A15 (4)
20 M 1/66

CERTIFICATE OF DEATH

11661		11656	
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRFAX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp. of Silver Spring</u>		d. STREET ADDRESS <u>3408 Jermantown Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> ^{First} <u>Baby</u> ^{Middle} <u>GIRL</u> ^{Last} <u>SMITH</u>		4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Aug. 18, 1966</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>7</u> IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u> Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Silver Spring, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert L. Smith</u>		14. MOTHER'S MAIDEN NAME <u>MARY J. Pyron</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>FATHER (Robert L.)</u>		Address <u>SOME AS ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MENINGOMYELOCELE</u> <u>7511</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 18, 1966</u> , to <u>Aug. 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug. 25, 1966</u> , and that death occurred at <u>10:25 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph A. Dugan</u>		22b. DATE SIGNED <u>8/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph A. Dugan</u>		22d. ADDRESS <u>50 W Edmonston Dr. Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/30/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairfax Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Fairfax Va.</u>
24. FUNERAL DIRECTOR <u>David W. Grundall</u> Everly Funeral Home		25a. REC'D BY REGISTRAR <u>AUG 30 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11556

STATE OF DEATH

11556

C



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

ITEM # FILM 251 9/21/77 re MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
11662				CERTIFICATE OF DEATH				11657			
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>						d. STREET ADDRESS <u>816 FAIR OAK AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIA</u> Middle <u>G.</u> Last <u>SMITH</u>						4. DATE OF DEATH Month <u>AUGUST</u> Day <u>7</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/25/07</u>		9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER-COUNSELLOR</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>SOUTH CAROLINA, GREENWOOD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRISON MORSE</u>						14. MOTHER'S MAIDEN NAME <u>WILLIA MORSE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY INSUFFICIENCY</u> <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>BRONCHOPNEUMONIA</u> DUE TO (c) <u>BRONCHOGENIC CARCINOMA LUNG</u> <u>19TH STAGES</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>7 DAYS</u> <u>7-8 MONTHS</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>FEB.</u> , 19 <u>66</u> , to <u>7 AUG.</u> , 19 <u>66</u> , that (I) (<u>we</u>) lost saw the deceased alive on <u>6 AUG.</u> , 19 <u>66</u> , and that death occurred at <u>11:20</u> A.M., from causes and on the date stated above.											
22a. SIGNATURE <u>Henry R. Wolfe</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/7/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Henry R. Wolfe</u>						22d. ADDRESS <u>905 SHARIDAN ST. HYATTSVILLE, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-11-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u>				23d. LOCATION (City or Town) (County) (State) <u>Prince Georges, Md.</u>			
24. FUNERAL DIRECTOR <u>John T. Rhinoco</u>						ADDRESS <u>3015-12th St</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J...</u>	

11023

STATE OF DEATH

11023

Name of Deceased		Date of Death	
John Doe		1912	
Age		Sex	
35		Male	
Married		Single	
Cause of Death		Place of Death	
Heart Disease		Home	
Time of Death		Signature of Physician	
10:00 AM		[Signature]	
Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]	
Date of Burial		Place of Burial	
1912		Cemetery	
Signature of Undertaker		Signature of Registrar	
[Signature]		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #23b Film #G380 8/26/66 pc

11663

CERTIFICATE OF DEATH

11658

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE South Carolina b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charleston Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 4054 Ohara Avenue	
3. NAME OF DECEASED (Type or print) Lonnie-Alfonso De La Rosa SOTO		4. DATE OF DEATH August 20 19 66	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 August 1966
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Charleston, South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Felix Nino SOTO III		14. MOTHER'S MAIDEN NAME Esther DE LA ROSA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Mr. Felix Nino SOTO III, 4054 Ohara Avenue/		Address Charleston Heights, South Carolina	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart disease 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 19 1966 , to August 20, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 20 19 66 , and that death occurred at 1240AM , from causes and on the date stated above.			
22a. SIGNATURE J.J. Tomasovic		22b. DATE SIGNED 21 August 1966	
22c. PHYSICIAN'S NAME (Type) J.J. TOMASOVIC, CAPT MC USAF		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 22, 1966	23c. NAME OF CEMETERY OR CREMATORY Memorial Grounds Cemetery	23d. LOCATION (City or Town) (County) (State) Austin, Texas
24. FUNERAL DIRECTOR R. A. Pumphrey ADDRESS 7557 Wisconsin Ave., Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE AUG 24 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11558

11559

DEPARTMENT OF HEALTH

South Carolina

Montgomery

Charleston, South Carolina

Charleston

404 Olive Avenue

U. S. Naval Hospital

August

De la Hoya, 3-70

Islands-Islands

9 August 1955

Note

Charleston, South Carolina

W/A

W/A

Barber, W. A. ROSS

Edith Rine, 3-11

Charleston, South Carolina

W/A

W/A

Commercial Bank Building

XI

August 20, 1955

X 21 August 1955

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

11664

CERTIFICATE OF DEATH

11659

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Pr. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		d. STREET ADDRESS <u>625 Sheridan ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN + HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MORRIS (NMN) SPIKLOSER</u>		4. DATE OF DEATH <u>Aug. 12 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/22/09</u>
9. AGE (In years lost birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>TAVERN</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LOUIS SPEKLOSER</u>	
14. MOTHER'S MAIDEN NAME <u>HAMIE SANK</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES U.W.I.</u>	
16. SOCIAL SECURITY NO. <u>577-26-9210</u>		17. INFORMANT <u>MRS. Virginia Spikloser - SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolus</u> 410X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>Rheumatic Heart Disease</u> DUE TO (c) <u>(mitral stenosis and insufficiency)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden approx. 10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-10 1966</u> , to <u>8-12 1966</u> that (I) (we) lost the deceased alive on <u>8/10 1966</u> and that death occurred at <u>5:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Gilbert Hurwitz</u>		22b. DATE SIGNED <u>8/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>GILBERT HURWITZ</u>		22d. ADDRESS <u>1800 EYE ST. N.W. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/15/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR PARK CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>BERGEN COUNTY N.J.</u>
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>AUG 16 1966</u>	

11623

11623

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Date of Death	
Sex		Race		Place of Birth	
Marital Status		Occupation		Cause of Death	
Signature of Physician		Signature of Registrar		Signature of Witness	
Date of Issuance		Place of Issuance		Official Seal	

11665

CERTIFICATE OF DEATH

11660

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b ??	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home		d. STREET ADDRESS 5 Arrowood Terrace	
3. NAME OF DECEASED (Type or print) Eva		4. DATE OF DEATH Month August Day 22 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1883
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 4 Days 20 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Wherle		14. MOTHER'S MAIDEN NAME Elizabeth Wilhemina Decker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-48-7069T	
17. INFORMANT Charles F. Steele-Son-Same as Item #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis acute 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arterio-sclerosis-Severe (c) Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 3 1/2 Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to date , 19 66 , that (I) (we) last saw the deceased alive on 22 Aug 19 66 , and that death occurred at 11:30 M, from causes and on the date stated above.			
22a. SIGNATURE John G. Ball		22b. DATE SIGNED August 23, 1966	
22c. PHYSICIAN'S NAME (Type) John G. Ball		22d. ADDRESS 7936 Old Georgetown Rd, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8/24/1966	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR Robert A. Pumphrey		25a. REC'D BY REGISTRAR DATE AUG 24 1966	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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SECTION AT DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove non-join papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
11666														
Item 21 Form 9500 8/31/66 mh														
11661														
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 71 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY New York c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) New York d. STREET ADDRESS 2865 Kingsbridge Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Steven Michael Stern					4. DATE OF DEATH Month Day Year August 16 1966									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 3, 1941		9. AGE (in years last birthday) 24 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Floor covering			11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Herbert Stern					14. MOTHER'S MAIDEN NAME Marian Brodsky									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1958-1962					16. SOCIAL SECURITY NO. Not available					17. INFORMANT The Medical Records Address The Clinical Center, Bethesda, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from tracheostomy site cause unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lower motor neuron disease or motor neuropathy/ DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 hours 1 year														
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)														
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 6 , 19 66 , to August 16 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 16 , 19 66 , and that death occurred at 5:30 PM , from the causes and on the date stated above.														
22a. SIGNATURE David Pleasure					22b. DATE SIGNED August 16, 1966									
22c. PHYSICIAN'S NAME (Type) David Pleasure, M.D.					22d. ADDRESS The Clinical Center, NIH, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8-18-66		23c. NAME OF CEMETERY OR CREMATORY King Solomon Cemetery			23d. LOCATION (City, town or county) (State) Clifton, N.J.						
24. FUNERAL DIRECTOR Goldberg Funeral Home 4217 9th St. N.W., D.C.					25. REC'D BY REGISTRAR AUG 18 1966					25b. REGISTRAR'S SIGNATURE Charles Judge				

11861

11862

New York

Montgomery

New York

VI days

Bedford

1805 Kingsbridge Terrace

The Clinical Center, Bethesda, Maryland

August 10 1955

Steven

Michael

Steven

December 3, 1941

White

Male

U.S.A.

New York

Minor covering

Belmont

Marion Brodsky

Robert Stern

The Medical Research

Not available The Clinical Center, Bethesda, Maryland

1952-1953

Yes

6 hours

Examination from the laboratory also

1 year

Lower motor neuron disease or motor neuropathy

August 10 1955

5:30

June 6

August 10, 1955

August 10, 1955

The Clinical Center, NIH, Bethesda, Md.

David H. Brown, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11667		CERTIFICATE OF DEATH				11662			
Item #9		Film #5300 8/24/66 pc							
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg c. LENGTH OF STAY IN 1b 4 yrs 2½ mo. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Asbury Methodist Home for the Aged, Inc.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ST. MARY'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Katie Middle Shermartine Last Stevens			4. DATE OF DEATH Month August Day 12 Year 19 66						
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26, 1874		9. AGE (In years last birthday) 92 9/1 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher & housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) St. Mary's Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. B. Shermantine					14. MOTHER'S MAIDEN NAME Maria D. Sanner				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 215-54-5199		17. INFORMANT Address Asbury Methodist Home, Gaithersburg, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Generalized Arteriosclerosis OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 1 DAY 20 YRS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/1/62 , 19__, to 8/12/66 , 19__, that (I) (we) last saw the deceased alive on 8/12/66 , 19__, and that death occurred at 330 AM , from the causes and on the date stated above.									
22a. SIGNATURE Henry C. Scruggs					22b. DATE SIGNED 8/12/66			22c. PHYSICIAN'S NAME (Type) Henry C. Scruggs	
22d. ADDRESS 7720 Wisconsin Ave., Bethesda 14, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		8/15/66		Benezer		Great Mills, Md.			
24. FUNERAL DIRECTOR W. Clarke Hattaway					25a. REC'D BY REGISTRAR AUG 17 1966				
ADDRESS 2500 Landon Road					25b. REGISTRAR'S SIGNATURE J. Charles Judge				

50011

6811

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11663

CERTIFICATE OF DEATH

11663

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN lb 15-1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitarium		d. STREET ADDRESS 8511 Grubb Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN M. STONE		4. DATE OF DEATH Month Day Year August 9, 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-4-1875
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY — — —	
11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Spelman		14. MOTHER'S MAIDEN NAME Frances Bound	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. — — —	
17. INFORMANT Mrs. Leslie Silberberg, See Item #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Degenerative Cerebrovascular Disease DUE TO (c) Atherosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December, 1965 to Aug. 9, 1966 , that (I) (we) last saw the deceased alive on Aug. 4, 1966 , and that death occurred at 6:15 A.M. from causes and on the date stated above.			
22a. SIGNATURE Clifton R. Gruver		22b. DATE SIGNED 8/9/66	
22c. PHYSICIAN'S NAME (Type) Dr. Clifton R. Gruver		22d. ADDRESS 915 19th St. N.W. Washington, DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8-10-1966	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		25a. REC'D BY REGISTRAR DATE AUG 11 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11603

11603

STATE OF TEXAS

County of _____

County of _____

State of Texas

State of Texas

County of _____

County of _____

State of Texas

State of Texas

County of _____

County of _____

State of Texas

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State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11669 CERTIFICATE OF DEATH 11664									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY ✓				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 76 Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Tampa 42-3				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					d. STREET ADDRESS 2303 W. Robeson Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Henry Strausbaugh			First Middle Last		4. DATE OF DEATH August 2 1966		Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1962		9. AGE (In Years last birthday) 4 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Indiana			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul E. Strausbaugh					14. MOTHER'S MAIDEN NAME Mary Sales				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address The Medical Records The Clinical Center, Bethesda, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphocytic Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia, hemolytic and gastrointestinal bleeding, fatty liver								INTERVAL BETWEEN ONSET AND DEATH minutes 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 18, 1966 , to August 2, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 2, 1966 , and that death occurred at 3:05M , from the causes and on the date stated above.									
22a. SIGNATURE Martin H. Cohen			22b. DATE SIGNED August 2, 1966		22c. PHYSICIAN'S NAME (Type) Martin H. Cohen, M.D.				
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			22e. ATTENDING MED. PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 8-4-66			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Myrtle Hill Cemetery		23d. LOCATION (City, town or county) (State) Tampa, Florida		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland			ADDRESS		25a. REC'D BY REGISTRAR AUG 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

1100A

1100B

Florida

Montgomery

Tampa

7th Day

Rebecca

The Clinical Center, Bethesda, Maryland, 3503 E. Wisconsin Avenue

Robert Henry Schussman August 1, 1960

Male White March 2, 1960

ORIGIN None Indian U.S.A.

Mary Gales

Paul E. Hirschman

The Medical Records
The Clinical Center, Bethesda, Maryland

Cardiac Arrest Minutes

Acute lymphocytic leukemia 2 months

Anemia, hemolytic and gastrointestinal bleeding, bloody liver

August 1, 1960

August 2, 1960

August 1, 1960
The Clinical Center, Medical
Institution of Health, Bethesda, Maryland

William H. Cohen, M.D.

Robert A. Murphy, Bethesda, Maryland
August 1, 1960

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11670

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11665

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>9 Mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Congressional Manor Nursing Home</u>				d. STREET ADDRESS <u>2900 Connecticut Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Dorette</u> Middle <u>Taylor</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>1966</u>			
5. SEX <u>Fe.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/6/1888</u>	
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George P Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Georganna Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>577-42-7833</u>		17. INFORMANT <u>F.R. Taylor, M^{le} Lean, Va.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Insufficiency Acute</u> DUE TO (b) <u>Uremia</u> DUE TO (c) <u>Cardio-Vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>1 month</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John B. Boll</u>		EXAMINER'S NAME (Type) <u>John B. Boll</u>		M.D. <u>8/8/66</u>		22. DATE SIGNED <u>8/8/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/10/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Andrew Chapel</u>		23d. LOCATION (City or Town) (County) (State) <u>Vienna Rd. Fairfax Va.</u>	
24. FUNERAL DIRECTOR <u>B.I. bank</u>				25a. REC'D BY REGISTRAR <u>AUG 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11602

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11671					11666				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Montgomery			a. STATE		Maryland		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Silver Spring			b. COUNTY		Montgomery		
c. LENGTH OF STAY IN 1b		10 years			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Silver Spring		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?		
1307 Cresthaven Drive					1307 Cresthaven Drive		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			
First Middle Last			Month Day Year			Female			
Elizabeth Catherine Taylor			August 10 1966						
6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Caucasian		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		Oct. 9, 1884		81 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		XX Own Home		Washington, D. C.		U. S. A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
John W. Maxwell				XXXXXXXXX Elizabeth McLaughlin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT			
No				None		Mrs. Helen J. Sallust			
				578-01-0503B		1307 Cresthaven Dr. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
170X DUE TO Metastatic Carcinoma									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Primary Carcinoma Rt Breast									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour a.m. p.m. 19			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
21. I certify that (I) (this hospital) attended the deceased from Sept 1949, to Aug 10, 1966, that (I) (we) last saw the deceased alive on Aug 10, 1966, and that death occurred at 10A M, from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
Ermo P. Ingel					Aug 10, 1966				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
Ermo P. Ingel					1222 Monroe St., N. E., D. C.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		Aug. 13, 1966		Glenwood Cemetery		Washington, D. C.			
24a. FUNERAL DIRECTOR		24b. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John B. Thomas		8434 Georgia Ave. Silver Spring, Md.		AUG 15 1966		J. L. J. Judge			

30013

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

1997

1000

1992

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11672

CERTIFICATE OF DEATH

11667

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3709 Chevy Chase Lake Drive		d. STREET ADDRESS 3709 Chevy Chase Lake Dr.	
3. NAME OF DECEASED (Type or print) First IRVING Middle HENRY Last TAYLOR		4. DATE OF DEATH Month August Day 2 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 15, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Export Director		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years last birthday) yrs. 70
11. BIRTHPLACE (County & State, or foreign country) Ontario, Canada		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Irving H. Taylor		14. MOTHER'S MAIDEN NAME Nettie Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 579-18-0132	17. INFORMANT Wife Lavinia Taylor Address Same as Item 2.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Cerebral Hemorrhage - DUE TO (c) Nephrosclerosis.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 19, 1966 to Aug 2, 1966 , that (I) (we) last saw the deceased alive on July 28, 1966 , and that death occurred at 10 P.M. from causes and on the date stated above.			
22a. SIGNATURE William L. Howell		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8-3-66
22c. PHYSICIAN'S NAME (Type) WILLIAM L. HOWELL		22d. ADDRESS 5401 Western Ave NW	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 8/3/1966	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Prince Georges Maryland
24. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS Bethesda, Maryland	25a. REC'D BY REGISTRAR AUG 5 1966
		25b. REGISTRAR'S SIGNATURE Charles Judge	

11607

CONTINUED OF FORM

11607

Name of Person		Date of Birth		Sex		Race		Religion		Marital Status		Occupation		Education		Income		Assets		Liabilities		Other Information	
John Doe		12/15/1925		Male		White		Catholic		Single		Teacher		High School		\$12,000		\$5,000		\$2,000		None	
Jane Doe		08/22/1928		Female		White		Catholic		Married		Homemaker		High School		\$12,000		\$5,000		\$2,000		None	
Robert A. Doe		03/10/1930		Male		White		Catholic		Single		Student		College		\$5,000		\$1,000		\$500		None	
Mary Jane Doe		07/05/1935		Female		White		Catholic		Single		Student		College		\$5,000		\$1,000		\$500		None	
William Doe		01/20/1940		Male		White		Catholic		Single		Student		College		\$5,000		\$1,000		\$500		None	
Elizabeth Doe		09/12/1945		Female		White		Catholic		Single		Student		College		\$5,000		\$1,000		\$500		None	
James Doe		11/01/1950		Male		White		Catholic		Single		Student		College		\$5,000		\$1,000		\$500		None	
Margaret Doe		06/18/1955		Female		White		Catholic		Single		Student		College		\$5,000		\$1,000		\$500		None	
Charles Doe		04/03/1960		Male		White		Catholic		Single		Student		College		\$5,000		\$1,000		\$500		None	
Susan Doe		02/14/1965		Female		White		Catholic		Single		Student		College		\$5,000		\$1,000		\$500		None	
David Doe		10/25/1970		Male		White		Catholic		Single		Student		College		\$5,000		\$1,000		\$500		None	
Jennifer Doe		05/11/1975		Female		White		Catholic		Single		Student		College		\$5,000		\$1,000		\$500		None	
Michael Doe		03/28/1980		Male		White		Catholic		Single		Student		College		\$5,000		\$1,000		\$500		None	
Ashley Doe		07/19/1985		Female		White		Catholic		Single		Student		College		\$5,000		\$1,000		\$500		None	
Christopher Doe		09/07/1990		Male		White		Catholic		Single		Student		College		\$5,000		\$1,000		\$500		None	
Stephanie Doe		11/23/1995		Female		White		Catholic		Single		Student		College		\$5,000		\$1,000		\$500		None	

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE RECORDS OF THE BUREAU OF THE CENSUS, AS MAINTAINED BY THE BUREAU OF THE CENSUS, WASHINGTON, D. C.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11673

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11668

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 13 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		d. STREET ADDRESS 4211 Woodberry St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Louis First Middle Last Temme		4. DATE OF DEATH Month 8 Day 5 Year 19 66	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer		10b. KIND OF BUSINESS OR INDUSTRY Meat Packing Ind.	9. AGE (In years last birthday) yrs. 95 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME - Temme		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 16. INFORMANT Daughter Address Elizabeth Carpenter - Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Uremia DUE TO (b) Nephritis - Chronic DUE TO (c) Cardio-Vascular Disease			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 months years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of Right H.P.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in Nursing Home - when getting into bed.	
20c. TIME OF INJURY Month, Day, Year Hour 5:15 p.m. 6/13 19 66	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home	20f. (City or town) (County) (State) Potomac - Mont. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball EXAMINER'S NAME (Type) John G Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 8/5/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 9, 1966	
23c. NAME OF CEMETERY OR CREMATORY Highwood Cemetery		23d. LOCATION (City or Town) (County) (State) Pittsburg Pa.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 8 1966	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When page 3 is removed, carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

11674

CERTIFICATE OF DEATH

11669

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>114 - Summerfield Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>N.</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/3/91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Land appraiser Dept of Agriculture</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nebraska</u>	9. AGE (In years, lost birthday) <u>75</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph A. Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Addie Neilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	
17. INFORMANT <u>Marie Thomas</u>		Address <u>1523 Rose</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema and congestion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>due to intestinal obstruction</u> DUE TO (c) <u>due to adenocarcinoma, Descending Colon</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>May</u> , 19 <u>65</u> , to <u>August 28, 1966</u> , that (1) (we) last saw the deceased alive on <u>August 28, 1966</u> , and that death occurred at <u>5:55</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Wesley S. Norton</u>		22b. DATE SIGNED <u>8/29/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-31-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 3 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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11000

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11675

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11670

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. + Hospital</u>			d. STREET ADDRESS <u>523 Dale Dr. #3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>NICHOLAS LAZARUS THOMAS</u>			4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1966</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>11-25-1893</u>		9. AGE (In years last birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>chef</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>		11. BIRTHPLACE (State or foreign country) <u>Turkey</u>	
13. FATHER'S NAME <u>Lazarus Thomad's</u>			14. MOTHER'S MAIDEN NAME <u>Barthania - Unk -</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Daughter - Bonnie Garcia</u>	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Belden R. Reap</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELOEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>8/20/1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-22-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	
23d. LOCATION (City or Town) <u>Washington, D.C.</u>		23e. REC'D BY REGISTRAR <u> </u>		23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. FUNERAL HOME ADDRESS <u>Rinaldi Funeral Home, 7400 Georgia Ave, NW</u>					

11050

UNITED STATES DEPARTMENT OF AGRICULTURE

75012

11050

11050

[Faint, mostly illegible text covering the main body of the page, possibly a report or document.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 644 hrs. - 30 min.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital				e. STREET ADDRESS 426 LINCOLN AVENUE				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roderick DeLaRoche Thomas		4. DATE OF DEATH August 30 1966		5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-28-98		9. AGE (In years last birthday) 68 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SPORTSWRITER - RETIRED		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? AMERICA		13. FATHER'S NAME John D. Thomas		14. MOTHER'S MAIDEN NAME Lillian Kendrick		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes - Army 1917-18		16. SOCIAL SECURITY NO. 578-09-8675	
17. INFORMANT CHART		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X DUE TO (b) Bronchopneumonia DUE TO (c) Bacterial infection		INTERVAL BETWEEN ONSET AND DEATH Hours Days Days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3 AUG, 1966 to 30 AUG, 1966 , that (I) (we) last saw the deceased alive on 30 AUG 1966 , and that death occurred at 11:54 PM , from the causes and on the date stated above.									
22a. SIGNATURE Kenneth Cruze		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Dr. Kenneth Cruze		22d. ADDRESS 7600 Carroll Ave. Takoma Park Md.		22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-2-1966		23c. NAME OF GEMETERY OR GEMATORY Arlington Nat'l. Cem.		23d. LOCATION (City, town or county) (State) Arlington, Va.		24. FUNERAL DIRECTOR Joseph Cawler's Sons, Inc.	
25a. REG'D BY REGISTRAR SEP 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 5130 Wisc. Ave. NW. Washington, D.C.		25d. DATE		25e. SIGNATURE	

35013

9011

John D. Thomas

2913

10. 02. 2014

-XENON-

FOR STATE
HEALTH DEPT.

11677

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11672

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> Montgomery b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>D.O.A.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>		d. STREET ADDRESS <i>12509 Farnell Dr.</i>	
3. NAME OF DECEASED (Type or print) <i>Frank Howard Tillotson</i>		4. DATE OF DEATH Month <i>8</i> Day <i>28</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 20, 1896</i>
9. AGE (In years last birthday) yrs. <i>70</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Bus Mechanic</i>	11. BIRTHPLACE (State or foreign country) <i>Connecticut</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Frank Tillotson</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes</i>	
16. SOCIAL SECURITY NO. <i>406-16-8221</i>		17. INFORMANT <i>Pauline Mangin</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary thrombosis</i> <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Coronary artery heart disease</i> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <i>8/28/1966</i>		23. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
24. FUNERAL DIRECTOR <i>Clark & Wilson</i>		25. REC'D BY REGISTRAR <i>Charles Judge</i>	
26. DATE THEREOF <i>Sept. 1, 1966</i>		27. LOCATION (City or Town) (County) (State) <i>South Norwalk, Conn.</i>	
28. NAME OF CEMETERY OR CREMATORY <i>Riverside Cemetery</i>		29. ADDRESS <i>434 Georgia Ave. Silver Spring, Md.</i>	
30. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		31. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return event within 72 hours after death.

85011

UNITED STATES DEPARTMENT OF AGRICULTURE

1187



OFFICE OF THE SECRETARY

WASHINGTON, D. C.

1917

REPORT OF THE SECRETARY

OF THE DEPARTMENT OF AGRICULTURE

FOR THE YEAR 1916

AND FOR THE PERIOD

FROM JANUARY 1, 1915

TO DECEMBER 31, 1916

IN ACCORDANCE WITH

THE ACT OF MARCH 3, 1907

CHAP. 110, § 10

STAT. 1035

U. S. GOVERNMENT PRINTING OFFICE

WASHINGTON, D. C.

1917

CLARK, W. B.

SECRETARY

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11678

11673

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>222 Elizabeth Ave.</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md.</u> d. STREET ADDRESS <u>222 Elizabeth Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Martha S. Timbers</u>			4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1966</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 16, 1907</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>
13. FATHER'S NAME <u>Alfred Ricks</u>			14. MOTHER'S MAIDEN NAME <u>Sadie Lee</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO. <u> </u>		
17. INFORMANT <u>Samuel Timbers</u> Address <u>item #2</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> DUE TO (b) <u>Kennec's anemia</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u> </u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	2Df. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-17-1966</u> to <u>8-18-1966</u> , that (I) (we) last saw the deceased alive on <u>8-17-1966</u> , and that death occurred at <u>5:38</u> p.m. from the causes and on the date stated above.					
22a. SIGNATURE <u>D.C. Bucy</u>			22b. DATE SIGNED <u>8-19-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>D.C. Bucy</u>			22d. ADDRESS <u>809 Veras Mill Rd Rockville</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/20/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		23d. LOCATION (City, town or county) (State) <u>Rockville Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swanda</u> ADDRESS <u>Rockville, Md.</u>			25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>AUG 25 1966</u>		
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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11679

CERTIFICATE OF DEATH

11674

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNIVERSITY NURSING HOME		d. STREET ADDRESS 1007 LAREDO ROAD	
3. NAME OF DECEASED (Type or print) RUTH ADELAIDE TIMMONS		4. DATE OF DEATH Month AUGUST Day 30 Year 1966	
5. SEX F	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-1902
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 4 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON - D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Cordell		14. MOTHER'S MAIDEN NAME Lucy Ryan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT James H. Timmons		1007 Laredo Rd. Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) 150X (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPERTENSION, ESSENTIAL			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from FEB. 14, 1953 , to AUG. 30, 1966 , that (I) (we) last saw the deceased alive on AUG. 30, 1966 , and that death occurred at 10:15 P.M. , from causes and on the date stated above.			
22a. SIGNATURE James A. Roberts		22b. DATE SIGNED 8/30/66	
22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS		22d. ADDRESS 8707 GEO. AVE. SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 2, 1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR John B. Thomas Warner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR SEP 2 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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45011

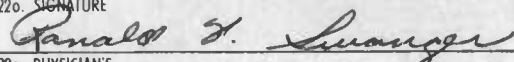
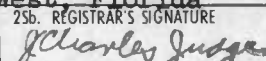
2381

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11680

CERTIFICATE OF DEATH

11675

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)			c. LENGTH OF STAY IN IB 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS Lot 216, 8141 Shore Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Patrick Middle Webb Last TRIBBEY, JR.				4. DATE OF DEATH Month August Day 13 Year 19 66			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 May 1966		9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2 Days 27	IF UNDER 24 HRS. Hours 27 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A			10b. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (County & State, or foreign country) Portsmouth, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick Webb TRIBBEY, SR.				14. MOTHER'S MAIDEN NAME Clara Maria NUNEZ			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) (If yes give year or dates of service) N/A			16. SOCIAL SECURITY NO. NONE	17. INFORMATION Shore Drive Address Norfolk, Va. Patrick Webb Tribbey, Sr., Lot 216, 8141			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary stenosis with severe congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from Aug. 12, 1966, to Aug. 13, 1966, that (X) (we) last saw the deceased alive on Aug. 13, 1966, and that death occurred at 435P M, from causes and on the date stated above							
22a. SIGNATURE 				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Aug. 15, 1966	
22c. PHYSICIAN'S NAME (Type) Ronald F. Swanger, M. D.				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-18-66	23c. NAME OF CEMETERY OR CREMATORY Key West Cemetery		23d. LOCATION (City or Town) (County) (State) Key West, Florida		
24. FUNERAL DIRECTOR Joseph Gawler & Sons ADDRESS 5130 Wisconsin Ave., N. W. Washington, D.C.				25a. REC'D BY REGISTRAR AUG 19 1966		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 47 hours after death.

VR A15 (4)
20 M 1/66

2130 Wisconsin Ave., N.W., Washington, D.C.

Joseph G. Grier & Son

100 West Conover

Key West, Florida

Donald E. Grier, M.D.

U. S. Naval Hospital, Bethesda, Md.

James J. Grier

12 Aug. 1968

13 Aug. 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11681
CERTIFICATE OF DEATH
11676

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOLY CROSS		d. STREET ADDRESS 407 GRANVILLE	
3. NAME OF DECEASED (Type or print) First Frank Middle Jr. Last Turner		4. DATE OF DEATH Month Aug Day 15 Year 1966	
5. SEX M	6. COLOR OR RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR		9. AGE (In years last birthday) 71 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME Frank S. Turner		12. CITIZEN OF WHAT COUNTRY? U.S.A	
14. MOTHER'S MAIDEN NAME Elijah Clark		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown	
16. SOCIAL SECURITY NO. 578-09-2547		17. INFORMANT Mrs. Helen M. Turner Address 407 Granville St. Silver Spring MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemoperitoneum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Status following needle biopsy of spleen DUE TO (c) Agnogenic myeloid metaplasia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1, 1966 to Aug 15, 1966 that (I) (we) last saw the deceased alive on Aug 14, 1966 and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE George L. Ball			
22b. DATE SIGNED Aug 15, 1966			
22c. PHYSICIAN'S NAME (Type) George L. Ball			
22d. ADDRESS 10620 Res. Ave. Silver Spring MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF Aug 18, 1966			
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			
23d. LOCATION (City, town or county) (State) Washington D.C.			
24. FUNERAL DIRECTOR Arthur Walker Address 254 Carroll St. N.W. Washington, D.C. 20012			
25a. REC'D BY REGISTRAR AUG 17 1966			
25b. REGISTRAR'S SIGNATURE Charles Judge			

11878

11878

Hemorrhoids

Stomach following needle biopsy of spleen

Agonistic myeloid metaplasia

11682

CERTIFICATE OF DEATH

11677

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>10 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>		d. STREET ADDRESS <u>9820 Dameron Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>G</u> Last <u>UNGER</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23 1881</u>
9. AGE (In years last birthday) <u>85</u> Yrs.		10. IF UNDER 1 YEAR Months <u>28</u> Days <u>19</u> Hours <u>66</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-----</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEBRASKA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>OLIVER P UNGER</u>		14. MOTHER'S MAIDEN NAME <u>ROSE ENNIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Harley J Unger</u>		Address <u>9820 Dameron Dr Silver Spring</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> DUE TO (b) <u>Nephrosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Recent Probable Hypertension</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/22</u> , 19 <u>65</u> , to <u>8/28</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>8/26</u> 19 <u>66</u> and that death occurred at <u>9:15 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Michael R. Dobridge</u>		22b. DATE SIGNED <u>Aug 28/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Michael R. Dobridge</u>		22d. ADDRESS <u>10620 Ga. Ave. Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	23b. DATE THEREOF <u>8/30/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory Prince Georges County, Md</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>The H.H. Hines Co. 2901 14th St. N.W.</u>		25. REC'D BY REGISTRAR <u>DATE AUG 30 1966</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

11653

3015

CERTIFICATE OF DEATH

11683

11678

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>15-1</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>9905 E. LIGHT DR.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GERALD</u> Middle <u>A.</u> Last <u>VILLELLA</u>		4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/6/23</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mar. - Credit Union</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't</u>	11. BIRTHPLACE (County & State, or foreign country) <u>OHIO</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>PATSY Villella</u>	
14. MOTHER'S MAIDEN NAME <u>MARtha PLASTINE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u>	
16. SOCIAL SECURITY NO. <u>YES (UNK)</u>		17. INFORMANT <u>LORENAINE Villella</u> Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary depression</u> <u>237X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Status post Craniotomy</u> DUE TO (c) <u>Brain Tumor - Posterior Fossa</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>14 hrs</u> <u>6 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-24</u> , 19 <u>66</u> , to <u>8-27</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>8-26</u> , 19 <u>66</u> , and that death occurred at <u>4A</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Jonathan M. Williams</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>8-27-66</u>
22c. PHYSICIAN'S NAME (Type) <u>Jonathan M. Williams</u>		22d. ADDRESS <u>808 Pershing Dr. Silver Spgs</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/30/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Wheaton Md</u>
24. BURIAL-DIRECTOR <u>Wm. J. Attwell</u>		ADDRESS <u>3603 14th St NW Wash DC</u>	25a. REC'D BY REGISTRAR <u>Charles Judge</u>
25b. REGISTRAR'S SIGNATURE		DATE <u>AUG 30 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11038

11832

Richard, Chapman
Staten foot (presumably)
Brim Tunes (Brim Tunes)

Jonathan M. Williams
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11684

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11679

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3201 Henderson Ave.</u>		d. STREET ADDRESS <u>3201 HENDERSON AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>H</u> Last <u>Wahlstrom</u>		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 19 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>62</u>
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THEODORE K. BRYANT</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELLEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-34-7402</u>	
17. INFORMANT <u>EUGENE T. WAHLSTROM</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute asphyxiation due to</u> <u>9210</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aspiration of gastric contents</u> DUE TO (c) <u>secondary to intestinal obstruction</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased aspirated vomitus and was asphyxiated.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2:15</u> p.m. <u>8-24</u> 19 <u>66</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELOEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/27/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>MONTGOMERY Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25. REC'D BY REGISTRAR DATE <u>AUG 26 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>		22. DATE SIGNED <u>8/24/1966</u>	

11032

11032

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11685

CERTIFICATE OF DEATH

11680

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 2600 Ridge Road Drive	
3. NAME OF DECEASED (Type or print) First Edna Middle Tucker Last WALKUP		4. DATE OF DEATH Month August Day 12 Year 1966	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 11, 1913
9. AGE (In years last birthday) yrs. 52		IF UNDER 1 YEAR Months 12 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Oriskany, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Tilden Tucker		14. MOTHER'S MAIDEN NAME Ardelia Rose Drummond	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Dr. Alexandria Address Va.		18. Captain Homer A. Walkup, USN, 2600 Ridge Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Colon with Metastasis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from July 14, 1966 , to Aug. 12, 1966 , that it (we) last saw the deceased alive on Aug. 12, 1966 , and that death occurred at 900A M. from causes and on the date stated above.			
22a. SIGNATURE H. E. Ashworth		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) H. E. Ashworth, M. D.		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 8-15-66	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington, Va.	
24. FUNERAL DIRECTOR Everly-Wheatley Funeral Home 1500 Braddock Rd., Alexandria, Virginia		25a. REC'D BY REGISTRAR AUG 15 1966	
25b. REGISTRAR'S SIGNATURE J. S. [Signature]		25c. REGISTRAR'S SIGNATURE J. Charles [Signature]	

11680

11687

Virginia

Montgomery

Alexandria

30 days

Baltimore (Maryland)

2000 Miles Road Trip

U. S. Naval Hospital

WATSON

Tucker

Bliss

Sept. 1, 1913

Baltimore, Md.

USA

Oriskany, Virginia

W/A

Baltimore

Arlington National Cemetery

General Tilden Tilden

U. S. Naval Hospital
 2000 Miles Road Trip
 Captain James A. Watson, USN, 2000 Miles Rd.

W/A

no

Continuation of the U.S. Naval Hospital

U. S. Naval Hospital, Baltimore, Md.

J. A. Ashworth, M. D.

Arlington National Cemetery, Arlington, Va.

1901 Road Trip
 U. S. Naval Hospital, Alexandria, Virginia
 AUG 15 1913

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11686

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11681

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Seneca</u>		c. LENGTH OF STAY IN 1b <u>1 hr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seneca Creek</u>		e. STREET ADDRESS <u>406 Blandford St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Raymond</u> Last <u>Walters</u>		4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1944</u>
9. AGE (In years lost birthday) <u>21</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>9</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph B. Walters</u>		14. MOTHER'S MAIDEN NAME <u>Annie Thorpe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Nancy Jean Walters-Wife-Same as Rockville Police - Item #2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia from Drowning</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>boat swamped in creek couldn't swim.</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>3:45 pm</u> <u>8/21</u> <u>1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>creek</u>		20f. (City or town) (County) (State) <u>Seneca Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>8/21/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>		Address (Street, city, town, or county) <u>Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/23/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 24 1966</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11881

11881

Maryland

Plasterer

Joseph E. Walters

James H. Jones

James H. Jones
James H. Jones
James H. Jones

James H. Jones

James H. Jones

Maryland

James H. Jones

James H. Jones

James H. Jones

James H. Jones

James H. Jones

FOR STATE
HEALTH DEPT.

11687

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11682

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>10409 Armory Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph W. Ward</u>				4. DATE OF DEATH <u>Aug. 13 1966</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 29, 1905</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mont. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis G. Ward</u>				14. MOTHER'S MAIDEN NAME <u>Geannette Baron</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-22-8591</u>		17. INFORMANT <u>Daughter Alma Meyer-Silver Sp.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pneumonia & multiple scars</u> 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ OUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pulm. cirrhosis, moderate</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John H. Boll</u> M.O.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/13/66</u>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		23d. LOCATION (City or Town) (County) (State) <u>SILVER SPRING MD.</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO.</u>				25a. REC'D BY REGISTRAR <u>8655 GATEWAY AVE.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
				DATE <u>AUG 17 1966</u>			

11988

11988

11988

116883

CERTIFICATE OF DEATH

11688

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Wash, D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md</u>		c. LENGTH OF STAY IN lb <u>10 mos.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda-Silver Spring Nursing</u>		d. STREET ADDRESS <u>4201 Massachusetts Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Charles L. Watkins</u>		4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>Aug. 10, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Parliamentarian US Senate</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mt Ida Arkansas</u>	
13. FATHER'S NAME <u>John Allen Watkins</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Rebecca Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>	
17. INFORMANT <u>Charles Owen Watkins</u>		Address <u>714 E. Jefferson St. Detroit, Mich.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerotic heart disease</u> DUE TO (b) <u>3 mo.</u> (c) <u>0072</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pulmonary Tuberculosis (inactive), RUL lobectomy</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> to <u>Aug. 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug. 29, 1966</u> , and that death occurred at <u>1058</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Thomas L. Hartman</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>8/29/66</u>
22c. PHYSICIAN'S NAME (Type) <u>THOMAS L. HARTMAN</u>		22d. ADDRESS <u>2001 Eye N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>9-1-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Ida Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Mt. Ida, Arkansas</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 6 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

11883

11883

ENTRANCE OF DEATH

Name of Deceased		Date of Death	
John Doe		10/10/1910	
Place of Death		Cause of Death	
New York City		Heart Disease	
Age at Death		Sex	
45		Male	
Marital Status		Occupation	
Single		Teacher	
Religion		Burial Place	
Catholic		St. Mary's Church	
Signature of Physician		Signature of Coroner	
[Signature]		[Signature]	
Date of Report		Time of Report	
10/11/1910		10:00 AM	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11689

CERTIFICATE OF DEATH

11684

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8811 Colesville Road				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 8811 Colesville Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Albert Arthur Weiss				4. DATE OF DEATH Month August Day 4 Year 1966			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 April 1896	
9. AGE (in years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Owner				10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (County & State, or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S. of American							
13. FATHER'S NAME Nathan Weiss				14. MOTHER'S MAIDEN NAME Sophie Goldstein			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. —		17. INFORMANT Robert Weiss Address 2608 Northampton St. NW	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease (a), stating the underlying cause last. (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Burger's Disease (Intermittent Claudication) INTERVAL BETWEEN ONSET AND DEATH 1 Day 1 Year 2 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour e.m. — p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that (I) (this hospital) attended the deceased from January, 1948 to 4 August 1966 that (I) was last saw the deceased alive on 4 August 1966 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Samuel Dove M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4 August 1966	
22c. PHYSICIAN'S NAME (Type) SAMUEL DOVE				22d. ADDRESS 1801 Eye Street, N.W., #407 - Washington D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8/7/66		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gar. Cem. Falls Church, Va.		23d. LOCATION (City, town or county) (State) —	
24 FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons				ADDRESS 3501-14th St., N.W., Wash DC		25a. REC'D BY REGISTRAR AUG 8 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11024

11024

RECORDS OF DEATH

21 MAY 1919

1011 COL. VILLIARD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
11690										
CERTIFICATE OF DEATH										
Item 12 Film 9-79 8/18/66 mh 11685										
1. PLACE OF DEATH a. CDUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville, Maryland					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville, Maryland					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6812 Tilden Lane, Rockville, Maryland					d. STREET ADDRESS 6812 Tilden Lane					
3. NAME OF DECEASED (Type or print) First Agatha Middle Liu Last Whang					4. DATE OF DEATH Month August Day 6 Year 1966					
5. SEX Female		6. COLOR OR RACE Chinese		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 18, 1907		9. AGE (in years last birthday) 59 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) China		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter Address 6812 Tilden Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease (c)					INTERVAL BETWEEN ONSET AND DEATH 2 weeks					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 1965 , 19 65 , to 8/6/66 , 19 66 , that (I/we) last saw the deceased alive on 8/6/66 , 19 66 , and that death occurred at 6:17 M, from the causes and on the date stated above.										
22a. SIGNATURE Jay R. Shapiro					22b. DATE SIGNED 8/18/66		22c. PHYSICIAN'S NAME (Type) Dr. Jay R. Shapiro, M.D.			
22d. ADDRESS 8218 Wisconsin Ave					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8/9/66		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City, town or county) (State) Silver Spring, Maryland			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home					25a. REC'D BY REGISTRAR AUG 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

11682

11680

Rockville, Maryland
1515 Edison Lane, Rockville, Maryland
Rockville, Maryland

Chinese
January 12, 1967
China

1515 Edison Lane
Rockville, Maryland
Dunbar
Mrs. George Dunbar

[Faint handwritten notes and signatures]

Dr. Jay H. Shapiro, M.D.

From Doctor: Personal Home
1515 Rockville Lane
Rockville, Maryland
Date of Payment Received
Silver Spring, Maryland
8/2/68

11686

11691

CERTIFICATE OF DEATH

HUBERT CASSIUS WHITE

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Dakota Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dakota Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eventide - 700 Hudson Ave</u>		d. STREET ADDRESS <u>8520 Greenwood Ave</u>	
3. NAME OF DECEASED (Type or print) <u>HUBERT CASSIUS WHITE</u>		4. DATE OF DEATH <u>Aug. 22</u> 19 <u>66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16, 1876</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Vermont</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cassius White</u>		14. MOTHER'S MAIDEN NAME <u>Switchell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Ellen G. White (same as #2)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO (b) <u>Bronchopneumonia</u> DUE TO (c) <u>CVA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>Feb 4, 1966</u> , to <u>Aug 21, 1966</u> , that (1) (the) last saw the deceased alive on <u>Aug 21, 1966</u> , and that death occurred at <u>2:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>R. H. Sandstrom MD</u>		22b. DATE SIGNED <u>Aug 22, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. H. SANDSTROM</u>		22d. ADDRESS <u>7701 Carroll Ave. Jnk. Pk. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug. 27, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Knights Washington</u>	23d. LOCATION (City or Town) (County) (State) <u>Adelphi, Prince Georges Co. Md</u>
24. FUNERAL DIRECTOR <u>J. Arthur Walters, 254 Carroll & NW 1st</u>		25a. REC'D BY REGISTRAR <u>AUG 23 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11692

CERTIFICATE OF DEATH

11687

1. PLACE OF DEATH a. COUNTY <i>Montgomery Silver Spring MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>2161 Fairland Road</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Fairland Nursing Home</i>		d. STREET ADDRESS <i>9549 Rhode Island Ave</i>	
3. NAME OF DECEASED (Type or print) <i>George Whitehead</i>		4. DATE OF DEATH Month <i>August</i> Day <i>11</i> Year <i>1966</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-3-1877</i>
9. AGE (In years last birthday) <i>89</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BUILDING</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Beltsville Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm Whitehead</i>		14. MOTHER'S MAIDEN NAME <i>SARAH Mc DONALD</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217053522</i>	
17. INFORMANT <i>Haisy B. Whitehead</i>		Address <i>College Park Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> DUE TO (b) <i>Acute congestive heart failure</i> DUE TO (c) <i>arterio-sclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i> <i>3-4 days</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Atherosclerosis, Coronary Artery Disease, Hypertension</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 5</i> , 19 <i>66</i> , to <i>Aug 11</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Aug 11</i> 19 <i>66</i> and that death occurred at <i>10:30 P.M.</i> M. from causes and on the date stated above			
22a. SIGNATURE <i>John R Spencer</i>		22b. DATE SIGNED <i>8-11-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOHN R SPENCER</i>		22d. ADDRESS <i>BURTONSVILLE, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug 15, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St Johns Episcopal</i>		23d. LOCATION (City or Town) (County) (State) <i>Beltsville Prince Georges Md</i>	
24. FUNERAL DIRECTOR <i>F Guschi sons Hyattsville, Md</i>		25a. REC'D BY REGISTRAR <i>AUG 16 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

11883

LIBRARY OF CONGRESS

11883

THE LIBRARY OF CONGRESS
1054 DUBLIN ST. N.W.
WASHINGTON, D.C. 20540
U.S. GOVERNMENT PRINTING OFFICE: 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11693

11688

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		c. LENGTH OF STAY IN 1b <u>2 hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac Md - 15.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Potomac Valley Nursing Home</u>				d. STREET ADDRESS <u>1235 Potomac Valley Rd. Rockville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First Middle Last				4. DATE OF DEATH <u>August 11th</u> Month Day Year <u>Thurs 19 66</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 14, 1984</u>	
9. AGE in years (last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
13. FATHER'S NAME <u>Benjamin Whitley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Henson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>242-40-8305</u>		17. INFORMANT <u>Mrs Mary Coy, Gaithersburg Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphocytic lymphoma</u> 2021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1</u> , 19 <u>63</u> , to <u>8-11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-28</u> 19 <u>66</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>D. L. Bucy</u>				22b. DATE SIGNED <u>8-11-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>D. L. Bucy</u>				22d. ADDRESS <u>809 Veirs Mt Rd Rockville</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-15-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Comfort</u>		23d. LOCATION (City, town or county) (State) <u>Alexander Va</u>	
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>				25a. REC'D BY REGISTRAR <u>AUG 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, within any event within 72 hours after death.

11694

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11689

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>3236 Reservoir Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Ingham</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 6, 1945</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (In years last birthday) <u>20</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward L. Williams, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Christine Cromwell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Edward L. Williams, Jr. (see Item #2)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Transsection of Thoracic Aorta.</u> DUE TO (b) <u>Trauma - Motor cycle Accident -</u> DUE TO (c) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Crashed Head on into car when riding Motor cycle.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2:00</u> <u>8/28</u> <u>1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Bethesda Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John B. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/28/66</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>8-30-1966</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State) <u>Front Royal, Va.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 31 1966</u>	
ADDRESS <u>5130 Wisc. Ave. N.W. Wash. DC.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11695

11690

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo.</u> <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>2 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7208 Adelphi Rd. Hyattsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>				d. STREET ADDRESS <u>7208 Adelphi Rd. 162</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frederick V. Williams</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>24</u> Year <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-28-94</u>	
9. AGE (In years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months <u>24</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>6</u> Min. <u>6</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Binder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Joseph J. Williams</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Harris</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>223-09-5902</u>		17. INFORMANT <u>Isabelle F. Williams</u> Address <u>Hyattsville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Diabetic gangrene, lt. foot</u> DUE TO (c) <u>Gen. arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary heart failure</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/24</u> , 19 <u>66</u> , to <u>8/24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-24</u> , 19 <u>66</u> , and that death occurred at <u>9:30 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Abraham W. Davis</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/24/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DAVIS</u>				22d. ADDRESS <u>1106 Spring St S.E. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/27/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pk. Geo. Md.</u>	
24. FUNERAL DIRECTOR <u>F. Snicki sons</u> ADDRESS <u>Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED OF DEAN

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9)
6M 1/66

11696

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11691

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN lb <u>10 min.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>9621 Bredock Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Luttrell</u> Middle <u>S</u> Last <u>Willis</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>12</u> Year <u>1966</u>			
5. SEX <u>Fe.</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/12/16</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Takoma, Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kelph Hodges</u>				14. MOTHER'S MAIDEN NAME <u>Pierce</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>UNK.</u>		17. INFORMANT <u>Husband. Charles Willis</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cardio Vascular Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 hr.</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Bell</u> M.D.				22. DATE SIGNED <u>8/13/66</u>			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-16-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges, Md.</u>	
24. FUNERAL DIRECTOR <u>John T. Plevier Co. Robert L. Plevier</u>				25a. REC'D BY REGISTRAR <u>AUG 17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Wm. T. Oliver

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11697					11692						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Montgomery MARYLAND					a. STATE New Jersey b. COUNTY						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Colonia						
c. LENGTH OF STAY IN 1b 6 Days					d. STREET ADDRESS 203 Cypress Drive						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
Francis Bradley Winslow						August			2 19 66		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 November 1924		9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Supervisor				10b. KIND OF BUSINESS OR INDUSTRY (I.T.T.) Communications		11. BIRTHPLACE (County & State, or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Bradley Winslow					14. MOTHER'S MAIDEN NAME Helen Caldwell						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W.II					16. SOCIAL SECURITY NO. 081-18-7317		17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure 593X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hepatic Failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic heart disease, aortic stenosis & insufficiency, insufficiency mitral 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH 1 month 1 month	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 27 July , 19 66 , to 2 August , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2 August , 19 66 , and that death occurred at 9:10 PM , from the causes and on the date stated above.											
22a. SIGNATURE G. David Beiser					ATTENDING MED. PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> A.M.			22b. DATE SIGNED August 2, 1966			
22c. PHYSICIAN'S NAME (Type) G. David Beiser, M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 8-6-1966		23c. NAME OF CEMETERY OR CREMATORY ST GERTRUDE'S CEMETERY			23d. LOCATION (City, town or county) (State) COLONIA, N.J.			
24. FUNERAL DIRECTOR Ismael J. Gacula					25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge				

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>12 days/6 hrs/5 am</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>			d. STREET ADDRESS <u>3963 Wendy Crt.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Rubye</u> Middle <u>Mae</u> Last <u>Wood</u>			4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1966</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-29-99</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hs.wt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Tenn.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			13. FATHER'S NAME <u>Julius Harvey</u>		
14. MOTHER'S MAIDEN NAME <u>Sallie Anderson</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		
16. SOCIAL SECURITY NO. <u>156-36-9990</u>			17. INFORMANT <u>Lawrence A. Wood</u> Address <u>(same as above)</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>January 1965</u> to <u>Aug 30 1966</u> that (I) (we) last saw the deceased alive on <u>Aug 29 1966</u> , and that death occurred at <u>1:00</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Boris Rabkin</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug 30, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>		22d. ADDRESS <u>1019 University Blvd East</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sep. 1, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>		
24. FUNERAL DIRECTOR <u>Clark E. Wilson</u> <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Ave.</u> <u>Silver Spring, Md.</u>	25a. REC'D BY REGISTRAR DATE <u>SEP 1 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville, md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hosp. Takoma Park, md.</u>		d. STREET ADDRESS <u>4015 Sandy Spring Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Edna WOOTTEN</u>		4. DATE OF DEATH Month Day Year <u>AUG. 15 1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-28-1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. GOV'T.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clerk</u>	9. AGE (In years last birthday) <u>71</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMER. (USA)</u>	
13. FATHER'S NAME <u>Samuel H. Owens</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET Chambers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>1-28-1895</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Acute Congestive Heart Failure</u> DUE TO (b) <u>Acute Pulmonary Edema</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus; uremia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/12</u> , 19 <u>66</u> , to <u>8/13</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>8/12</u> , 19 <u>66</u> , and that death occurred at <u>10:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Smith, Jr.</u>		22b. DATE SIGNED <u>8/15/66</u>	
22c. PHYSICIAN NAME (Type) <u>Joseph E. Smith, Jr.</u>		22d. ADDRESS <u>Burtonsville, md</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/17/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Long Hill Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Laurel Pk Md.</u>	
24. FUNERAL DIRECTOR <u>De Witt Donaldson</u>		25a. REC'D BY REGISTRAR <u>John Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>		DATE <u>AUG 22 1966</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>11602 Gail St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bryan Boy Wright</u> First Middle Last 4. DATE OF DEATH <u>Aug 15 1966</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8/14/66</u> 9. AGE (In years last birthday) <u>20</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Edward Lee Wright</u> 14. MOTHER'S MAIDEN NAME <u>Anne Marie Fogle</u> Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Atelectasis</u> DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>8/14</u> , 19 <u>66</u> to <u>8/15</u> , 19 <u>66</u> . That (I) (we) last saw the deceased alive on <u>8/14</u> , 19 <u>66</u> and that death occurred at <u>2:15</u> P.M. from the causes and on the date stated above.	
22a. SIGNATURE <u>William M. Sterling M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>William M. Sterling M.D.</u> 22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>4700 Bradley Blvd. - CHOP Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8/17/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u> 23d. LOCATION (City, town or county) (State) <u>Prince George Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u> ADDRESS <u>1551 Rockville Pike</u> <u>Rockville, Maryland</u>		25a. RECEIVED BY REGISTRAR <u>AUG 18 1966</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Charles Juage</u>	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>16-2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San Hospital</u>				d. STREET ADDRESS <u>146 Ames Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Douglas Joseph</u> Middle <u>Wulf</u> Last <u>Wulf</u>				4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1966</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>apr 9-59</u>	9. AGE (In years last birthday) yrs. <u>7</u>	IF UNDER 1 YEAR Months <u>18</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>66</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>David W. Wulf Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Joan Glass</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>7545</u>		17. INFORMANT <u>mother & father</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u> DUE TO (b) <u>Congenital Heart Disease</u> DUE TO (c) <u>(Ebstein's Anomaly)</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Peap</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. PEAP M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>Aug 22, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
23d. LOCATION (City or Town) <u>Arlington Va</u>				23e. (County) <u>VA</u>		23f. (State) <u>VA</u>	
24. FUNERAL DIRECTOR <u>W. H. Altman</u>				25a. REC'D BY REGISTRAR <u>3603 14th St NW</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>Aug 22 1966</u>				DATE <u>Aug 22 1966</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11702 CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>					d. STREET ADDRESS <u>4938 Battery Lane</u>			15-1	
3. NAME OF DECEASED (Type or print) <u>Charles Ziehl</u> First Middle Last					4. DATE OF DEATH <u>8-8</u> Month Day Year <u>1966</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/12/08</u>		9. AGE (In years birthday) yrs. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethesda Fire Dept.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Paul C. Ziehl</u>					14. MOTHER'S MAIDEN NAME <u>Mary Ann Schwenke</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-03-8975</u>		17. INFORMANT Address <u>Wife - Josephine - Same</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> <u>1538</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Metastases from primary large bowel carcinoma</u> DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8-7-1966</u> to <u>8-8-1966</u> , that (I) (we) last saw the deceased alive on <u>8-7-1966</u> , and that death occurred at <u>3:00</u> M, from causes and on the date stated above.									
22a. SIGNATURE <u>Paul D. Cantor</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>August 9, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>Paul D. Cantor, M.D.</u>					22d. ADDRESS <u>4709 Montg. Lane, Bethesda, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/11/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Rockville Mtg. Maryland</u>		
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey Funeral-Bethesda, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>AUG 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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